STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155135	A. BUILDING _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW NURSING AND REHABILITATION CENTER	**1510 CLINIC DR BEDFORD, IN 47421**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00196696.

This visit was in conjunction with the Recertification and State Licensure Survey and the Investigation of Complaint IN00195396.

Complaint IN00196696 - Unsubstantiated due to lack of evidence.

Survey dates: March 31, April 1, 4, 5, 6, 7, 2016.

Facility number: 000060
Provider number: 155135
AIM number: 100266600

Census bed type:
SNF/NF: 74
Total: 74

Census payor type:
Medicare: 13
Medicaid: 48
Other: 13
Total: 74

Sample: 3

Westview Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Compliant IN00196696.

Q.R. completed by 14466 on April 14, 2016.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE